

H-R DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION				
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:	
SSN:	Phone:	Allergies:		
Address:		City:	State:	Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> Additional Information Attached	
PRESCRIBER INFORMATION				
Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT				
Primary Diagnosis: <input type="checkbox"/> L28.1 Prurigo nodularis <input type="checkbox"/> L40.0 Psoriasis <input type="checkbox"/> L40.1; L40.2; L40.3, L40.4, L40.8, L40.54 Psoriatic arthritis <input type="checkbox"/> L40.59 <input type="checkbox"/> L50.1 Chronic Idiopathic Urticaria <input type="checkbox"/> L73.2 Hidradenitis Suppurativa <input type="checkbox"/> Other: _____				
Location: <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Face <input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Others: _____ Severity: <input type="checkbox"/> Mild (up to 3% BSA) <input type="checkbox"/> Moderate (3-10% BSA) <input type="checkbox"/> Severe (greater than 10% BSA), BSA _____ % If treated previously for this condition, please indicate which drugs have been tried and failed: _____ Date range of previous therapy: _____ Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type/ medication(s): _____ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes, how long should patient wait before starting the new medication? _____ Has patient received a PPD (tuberculosis) Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.				
PRESCRIPTION INFORMATION				
<input type="checkbox"/> STC Standard Protocol will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and/or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM / 0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).				
Humira® <input type="checkbox"/> CF Pen Psoriasis Starter Kit NDC: 0074-1539-03 <input type="checkbox"/> Prefilled Syringe CF 40 mg/ 0.4 mL NDC: 0074-0243-02 <small>*Pen Starter Kit will be dispensed if no preference indicated</small>		<input type="checkbox"/> Enroll in Humira Complete Program QTY: <u>3 pens</u> Refills: <u>0</u> QTY: <u>4 syringes</u> Refills: <u>0</u>		
<input type="checkbox"/> Starter Dose for Psoriasis: <input type="checkbox"/> One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 (OR) <input type="checkbox"/> Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 <input type="checkbox"/> Starter Dose not needed.				
Humira® <input type="checkbox"/> CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 <input type="checkbox"/> CF 40 mg/0.4 mL Syringe NDC: 0074-0243-02 <small>*Pen will be dispensed if no preference indicated</small>		QTY: <u>1 month</u> Refills: _____		
<input type="checkbox"/> Maintenance Dose for Psoriasis: 40 mg SQ once every other week				
Humira® <input type="checkbox"/> Starter Pkg CF 80 mg/0.8 mL Pen NDC: 0074-0124-03 <input type="checkbox"/> CF Prefilled Syringe 40 mg/0.4 mL NDC: 0074-0243-02 <small>*Pen will be dispensed if no preference indicated</small>		QTY: <u>1 month</u> Refills: <u>0</u> QTY: <u>1 month</u> Refills: <u>0</u>		
<input type="checkbox"/> Starter Dose for Hidradenitis Suppurativa: <input type="checkbox"/> Inj 160 mg SQ day 1, then 80 mg SQ day 15 (OR) <input type="checkbox"/> Inj 80 mg SQ day 1, and 80 mg SQ day 2, then 80 mg SQ day 15 <input type="checkbox"/> Starter Dose not needed.				
Humira® <input type="checkbox"/> CF 40 mg/0.4 mL Pen NDC: 0074-0554-02 <input type="checkbox"/> CF 40 mg/0.4 mL Syringe NDC: 0074-0243-02		QTY: <u>1 month</u> Refills: _____ QTY: _____ Refills: _____		
<input type="checkbox"/> Maintenance Dose for hidradenitis suppurativa: 40 mg SQ Day 29 and every week thereafter <input type="checkbox"/> Other _____				
Ilumya® <input type="checkbox"/> 100 mg/mL Prefilled syringes		QTY: <u>1 month (1 PFS)</u> Refills: <u>0</u> QTY: <u>1 syringe</u> Refills: _____		
<input type="checkbox"/> Starter Dose: 100 mg SQ on Week 0 and Week 4 <input type="checkbox"/> Maintenance Dose: 100 mg SQ every 12 weeks (starting at week 4)				
Kevzara® (Sarilumab) <input type="checkbox"/> Pen autoinjector 200 mg/1.14 mL <input type="checkbox"/> Prefilled syringe 200 mg/1.14 mL <small>*Pens will be dispensed if no preference is indicated</small>		QTY: <u>1 box (2)</u> Refills: _____ QTY: <u>30 caps</u> Refills: _____		
<input type="checkbox"/> 200 mg subcutaneously every 2 Weeks				
Odomzo® <input type="checkbox"/> 200 mg Capsule PO Once Daily		QTY: <u>1 month</u> Refills: <u>0</u>		
Otezla® Tablets		QTY: <u>60 tabs (30mg)</u> Refills: _____ QTY: _____ Refills: _____		
<input type="checkbox"/> Titration Dose: Day 1: 10 mg in morning; Day 2: 10 mg in morning and 10 mg in evening; Day 3: 10 mg in morning and 20 mg in evening; Day 4: 20 mg in morning and 20 mg in evening; Day 5: 20 mg in morning and 30 mg in evening; Day 6 and thereafter: 30 mg twice daily <input type="checkbox"/> Maintenance Dose: 30 mg twice daily <input type="checkbox"/> Other _____				
<input type="checkbox"/> Remicade® 100 mg Vial <input type="checkbox"/> Inflectra® 100 mg Powder Vial <input type="checkbox"/> Renflexis® 100 mg Powder Vial <input type="checkbox"/> Avsola® 100 mg Powder Vial <input type="checkbox"/> MD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required		<input type="checkbox"/> Enroll in AccessOneSM Program QTY: <u>QS 3 infusions</u> Refills: <u>0</u> QTY: <u>QS 1 infusions</u> Refills: _____		
<input type="checkbox"/> Starter Dose: _____ mg IV on Week 0, Week 2, Week 6, then <input type="checkbox"/> Maintenance Dose: _____ mg IV every _____ Weeks				
Rinvoq® <input type="checkbox"/> 15mg tablet <input type="checkbox"/> 30mg tablet 1 tablet po once daily		QTY: <u>1 month</u> Refills: _____		

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed.

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